

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

823263-083550

FILED AUG 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN St Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hosp		d. STREET ADDRESS (If outside, give location) 1602^a N 14th Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Grnkovic Last		4. DATE OF DEATH Month Aug Day 10 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/6/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	9. AGE (last birthday) 73
13a. FATHER'S NAME Mate Cop		13b. MOTHER'S MAIDEN NAME Unknown	12. CITIZEN OF WHAT COUNTRY U S
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates) No		14. NAME OF HUSBAND OR WIFE Slavo	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Gen arteriosclerosis DUE TO (c) 332X		INTERVAL BETWEEN ONSET AND DEATH Approx 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1952 to 8/10/63 and last saw her alive on 8/10/63 Death occurred at H.P. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Sallan Wynn (Degree or title) M.D.		22b. ADDRESS 3915 Watson	22c. DATE SIGNED 8/13/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/14/63	23c. NAME OF CEMETERY OR CREMATORY S S Peter & Paul Cem	23d. LOCATION (City, town, or county) (State) St Louis Missouri
24. FUNERAL DIRECTOR Moydell Funeral Home 1926 Allen		25. DATE RECD. BY LOCAL REG. AUG 13 1963	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR TYPEWRITER RIBBON

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Hadley F. Jaeller Jr

Licensed Embalmer No.

4950

P. O. Address

St Louis

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.